

Public health *sans frontières*: human rights NGOs and “stewardship on a global scale”

THÉRÈSE MURPHY*

University of Nottingham

1 Introduction

Does the Nuffield report *Public Health: Ethical issues*¹ neglect non-governmental organisations (NGOs)? I think the answer has to be “yes” and in this article I set about explaining why I take this view and what might be done to fill the gap. The Nuffield report, to be fair, is not entirely silent on NGOs: it refers to them in its discussion of “third parties”, noting that all such parties have an “obligation to reflect on their role in public health”.² In total, however, there are just two paragraphs on NGOs (commercial organisations, another of Nuffield’s third parties, are discussed at much greater length). These paragraphs describe NGOs as “important stakeholders”. More particularly, they note that “whether [NGOs] are ‘grass roots’ or established national or multinational organisations”, they can have a “valuable role to play in policy development”. There is also a caution, however: “it should be borne in mind that NGOs may have a vested interest, a commercial imperative and a ‘product’ in a way that is not dissimilar to a business”.³

Two paragraphs on NGOs may seem more than enough. This, after all, is a report about the state – at core, its argument is that the state needs to adopt what it calls a “stewardship model” in the arena of public health.⁴ Thus it may be said that there was no reason for extended engagement with NGOs or, for that matter, with any other non-state actor. I take a different view, however. There are, of course, issues and instances when it is important to keep state and non-state separate; at the same time, however, I believe that being rigid about the distinction is likely to obscure one of the defining features of public health today: namely, the role of non-state actors, including the ways in which such actors work with, within and against the state, and at times as – or instead of – it. I believe, in other words,

* School of Law, University of Nottingham. My thanks to Mark Flear, the editor of this special issue, and to both Noel Whitty and the anonymous reviewer for comments on an earlier version.

1 Nuffield Council on Bioethics, *Public Health: Ethical issues* (London: Nuffield Council on Bioethics 2007), available at www.nuffieldbioethics.org/public-health (accessed 1 September 2011) (hereafter Nuffield report).

2 Ibid. para. 2.46. In similar vein, it notes that “the stewardship responsibility of the state does not absolve other parties . . . from their responsibilities” (para. 1.12).

3 Ibid. n. 1 above, paras 3.42–3.43.

4 The terms of reference do not, however, make direct mention of the state. Moreover, the corporate sector – a non-state actor – is discussed at some length in the report, and there are also recommendations concerning the WHO and “the international community”.

that we ought to be thinking in terms of public health *sans frontières* – of public health “without borders”.

By way of illustration, consider the HIV/AIDS epidemic. This has been – is – a devastating epidemic, and no account of it should omit either the terrible death toll (more than 25 million people have now died of HIV-related causes),⁵ or the ways in which government policies have added to the numbers of dead and dying, of orphans and child-headed households, and of those vulnerable to infection. To stop there, however, would make the account incomplete; most notably, it would mean leaving out the part played by non-state actors – from pharmaceutical companies and NGOs to organisations such as the Bill and Melinda Gates Foundation, the Clinton Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria.⁶ In this article I shall be looking at just one of these non-state actors – NGOs, and in particular global human rights NGOs. I have chosen these organisations for two reasons. First, ethical considerations are supposed to be their very essence: to put it crudely, human rights NGOs are meant to be about making an effort to “do good” in the world. They are, as Ong puts it, “practitioners of humanity”.⁷ Secondly, looking at the HIV/AIDS epidemic – an example I come back to again and again throughout the article – it is clear that such efforts have had a deep, even transformative, impact on how the illness is perceived and, relatedly, on what can and should be done to halt its spread and bring it to an end.

Translated into the language of the Nuffield report, we might say that via their work on HIV/AIDS, human rights NGOs have been engaged in “stewardship on a global scale”.⁸ Should that prove controversial – because for example it is only the state that should be seen in stewardship terms, or because stewardship is too problematic an idea – then the same basic point can be made by saying that human rights NGOs seem to be doing exactly what the Nuffield report recommends: that is to say, they are “third parties” that seek out a role in public health, taking on responsibilities rather than shrugging them off as obligations of the state, and the state alone.⁹

Yet, when the Nuffield report refers to global stewardship, the context is not NGOs or, indeed, HIV/AIDS or any of the other public health problems with which human rights NGOs have strong associations. In the report, global stewardship is an entry point for discussing ethical and legal obligations associated with “pandemic preparedness”; in other words, the obligations that stem from the need to tackle emerging and re-emerging infectious diseases such as SARS or virulent influenza.¹⁰ The report focuses in particular on a quartet of actors: states; the World Health Organization (WHO); the international community; and pharmaceutical companies. I have no quibble with any of these foci but, as I have said, I believe global stewardship points in another direction too: it points towards NGOs, and in particular towards human rights NGOs. So, with that in mind, I use this article to establish, first, why it is that human rights NGOs have be part of any account of public health stewardship on a global scale and, secondly, what this means in terms of the ethical issues facing such organisations. Put differently, I use this article to take some first steps towards an account of public health *sans frontières*.

5 UNAIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2010* (Geneva: UNAIDS 2010), available at www.unaids.org/globalreport/global_report.htm (accessed 1 September 2011).

6 See respectively www.gatesfoundation.org, www.clintonfoundation.org and www.theglobalfund.org (accessed 1 September 2011).

7 A Ong, *Neoliberalism as Exception: Mutations in citizenship and sovereignty* (Durham NC: Duke UP 2006), p. 198.

8 Nuffield report, n. 1 above, para. 4.68.

9 Ibid. para. 1.12.

10 Ibid. paras 4.47–4.55, 4.66–4.68.

2 Public health *sans frontières*

Let's begin by looking more closely at the part played by NGOs in the HIV/AIDS epidemic. Recall, for instance, that during the epidemic's earliest years it was a campaign by ACT-UP, a US-based NGO, that changed conventions on drug-testing and licensing, and that this in turn helped to accelerate the development of antiretrovirals (ARVs).¹¹ Later, at the Doha round of trade talks, it was the negotiating power of NGOs (working with a network of emerging and less-developed economies) that helped to secure a new configuration of trade and human rights via agreement on what is known as the Doha Declaration. That declaration affirmed that the WTO's Agreement on Trade-Related Aspects of Intellectual Property (TRIPS)¹² contains flexibilities – what Rochelle Dreyfuss calls “wiggle room”¹³ – that allow member states to get around patents on medicines when this is necessary in order to protect public health.¹⁴ It also set the scene for two further years of negotiation after which agreement was reached on a mechanism that gives more flexibility to states that have insufficient or no manufacturing capacity in the pharmaceutical sector, allowing them to bring in medicines from a foreign generic producer.¹⁵

Perhaps most notably of all, NGOs were key players when it came to building the case for universal access to treatment. In order to achieve this goal, NGOs fixed their attention on both “can and should”:¹⁶ thus, they called for access to be accepted and secured as a human right, as a global public good, but they did not stop there; they also demonstrated that universal access was achievable – that poor people did adhere to complex drug regimes,¹⁷ that treatment saved money as well as lives, and that the differential pricing and generics competition that could help to make ARVs more affordable was not going to imperil research and development (R&D) on global public health. The message reached its intended recipients: in 2006 the international community pledged universal access to HIV prevention, treatment, care and support — “as close as possible . . . by 2010 for all those who need it”¹⁸ – thereby bolstering the commitment, made in the Millennium Development Goals, to reverse the epidemic by 2015.

The best-known NGO in the HIV/AIDS field is probably Treatment Action Campaign (TAC), an organisation founded in South Africa by a “handful of people”¹⁹ on international human rights day in 1998. TAC's first campaign, launched on the same day, called on the

11 See S Epstein, *Impure Science* (Berkeley: University of California Press 1996).

12 Marrakesh Agreement Establishing the World Trade Organization, opened for signature 15 April 1994, 1867 UNTS 3, annex 1C (Agreement on Trade-Related Aspects of Intellectual Property Rights) (entered into force 1 January 1995) (TRIPS).

13 R C Dreyfuss, “TRIPS and essential medicines: must one size fit all? Making the WTO responsive to the global health crisis” in T Pogge, M Rimmer and K Rubenstein (eds), *Incentives for Global Public Health: Patent law and access to essential medicines* (Cambridge: CUP 2010), p. 55.

14 Declaration on the TRIPS Agreement and Public Health (adopted 14 November 2001) WTO Doc. WT/MIN(01)/DEC/2 (Doha Declaration).

15 Implementation of para. 6 of the Doha Declaration on the TRIPS Agreement and Public Health: Decision of 30 August 2003, WTO Doc. WT/L/540; Amendment of the TRIPS Agreement: Decision of 6 December 2005, WTO Doc. WT/L/641.

16 E B Kapstein and J W Busby, “Making markets for merit goods: the political economy of antiretrovirals” (2010) 1 *Global Policy* 75, p. 87.

17 See e.g. P Farmer, *Infection and Inequalities: The modern plagues* (Berkeley: University of California Press 1999).

18 UNGA Res. 60/262 (the “Political Declaration of Commitment on HIV/AIDS”), available at http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf (accessed 1 September 2011).

19 M Heywood, “South Africa's treatment action campaign: combining law and social mobilization to realize the right to health” (2009) 1 *Journal of Human Rights Practice* 14, p. 15.

South African government to implement a comprehensive national programme to prevent mother-to-child transmission (PMTCT) of HIV. Achieving that goal was, however, neither easy nor immediate. TAC had to battle the government both in and out of court, and it had to combine this with a range of other initiatives, including working *with* the government in order to challenge the drug-pricing practices of major pharmaceutical companies. Along the way, TAC encountered not just arguments in favour of patent protection on ARVs and other AIDS medicines, but also both AIDS denialism (and the dissident science that supported it) and a remarkably widespread belief that the right to health was non-justiciable. Put differently, TAC found itself in a “chain of disputes”²⁰ and, as Zackie Ahmat, a founding member and former chairperson of TAC, explains what was toughest of all was that some of these disputes gave the organisation no option other than taking on the ANC:

The difficult decision . . . was not to take off my suit and go to the streets and fight for treatment . . . That was easy. The emotionally torturous thing for me to do was to recognize we had to take on the ANC. *Our ANC*.²¹

By taking on the ANC on a matter of *health* policy, TAC compounded its problems. Intervening in this arena brought the organisation face-to-face with the legacy of apartheid – an era when “health” was used “to justify, first, racial segregation measures and, later, exploitation of the labor force . . . [when] tuberculosis and syphilis provided a foundation on which to construct theories of black inferiority and African sexual promiscuity”.²² It also brought TAC face-to-face with the appeal of traditional medicine, and with the view – popular amongst public health experts – that poor, ill-educated people were not going to adhere to treatment regimes.

Knowing this makes TAC’s achievements all the more remarkable: TAC paved the way not only for a nationwide programme for the prevention of MTCT but also a national ARV treatment plan for all those with HIV/AIDS. More than this, its treatment literacy campaign demonstrated just how wrong it was to assume that poor patients would not follow complex drug regimes. It also delivered a new generation of South African “biocitizens” – well-informed and ready to engage and make demands on matters of health policy. As of 2010, South Africa had one million people living with HIV on treatment, the largest number worldwide.²³ The country’s government had also increased the HIV budget by 33 per cent, and launched a campaign to test 15 million people by 2011 – a move that has been described by the Executive Director of UNAIDS as “the biggest national mobilization around any single issue since the end of apartheid and the largest HIV counselling, testing and treatment scale-up in the history of the HIV epidemic”.²⁴

To sum up then: locally, nationally and at the international level, NGOs have shaped responses to the HIV/AIDS epidemic. They have influenced law and policy, and in so doing they have challenged the taken-for-granted – including both the alleged non-justiciability of the right to health and the assumed deadlock between the trade view of the world and its human rights counterpart. More than this, NGOs have redirected research and become involved in directing it too, and they have also delivered prevention, care, treatment and support on the ground. To achieve these ends, NGOs formed networks amongst themselves, and they also partnered with states, international organisations and fellow non-

20 D Fassin, *When Bodies Remember: Experiences and politics of AIDS in South Africa* (Berkeley: University of California Press 2007), p. 70.

21 S Power, “Letter from South Africa: the AIDS rebel”, *New Yorker*, 19 May 2003, p. 65.

22 Fassin, *When Bodies Remember*, n. 20 above, p. xviii. It also led to encounters with dissident science, and with traditional medicine too.

23 UNAIDS, *2009 Report on the Global AIDS Epidemic* (Geneva: UNAIDS 2010), p. 29.

24 M Sidibé, *Delivering Results in Transformative Times* (Geneva: UNAIDS 2010), p. 8.

state actors (including new health-oriented super-philanthropists such as the Gates Foundation). In so doing, they helped to forge what is sometimes called “AIDS exceptionalism”; an unprecedented conjunction of state and non-state actors working towards the resolution of a public health problem, willing to consider and push ahead with new ways of thinking (such as the human rights approach to public health pioneered by Jonathan Mann, the first director of UNAIDS) and unwilling to let accepted ideas about “effective” health delivery stand in their way. They also of course provided a template that others, working on different public health problems, are now very keen to follow.

What I take from this is that a report on “public health: ethical issues” that does not engage fully with NGOs has to be seen as an incomplete report. The neglect of NGOs is more problematic still when we recall that the Nuffield report does not limit itself to engagement with the state and, moreover, that it brings the idea of “stewardship on a global scale” into play. In order to address that neglect, the remainder of this article draws out a range of points that could be part of a *revised* Nuffield report – a report that does engage with NGOs. What follows will be nowhere near a full engagement; for example, I spend no time examining the Nuffield Council’s understanding of stewardship or the pros and cons of applying that understanding to human rights NGOs. Instead, the emphasis is on shaping possible lines of enquiry: the aim is to give basic form and, more importantly, impetus to the argument that any viable account of “public health: ethical issues” has to incorporate NGOs – both the roles they are playing and the effects on states, on fellow non-state actors and, of course, on NGOs themselves.

The latter question is the one I focus on here. In what follows I look, first, at the relationship between human rights-based approaches to public health and their humanitarian counterparts; then, at the commitment of global human rights NGOs to economic, social and cultural (ESC) rights; and third and, finally, at the challenging nature of what we may call “human rights triage”.

3 Public health: ethical issues – the case of NGOs

I begin with a possible objection: namely, that as regards NGOs and the matter of “public health: ethical issues” the work has already been done – mostly by NGOs themselves via the production of codes of good practice. The best-known of such codes is the one prepared jointly by the International Federation of Red Cross and Red Crescent Societies and the International Committee of the Red Cross (ICRC): often called the Red Cross code, its full title is “The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief”,²⁵ and since its creation in 1994 it has been signed by hundreds of NGOs. Another increasingly well-known example is the Sphere Project’s “Humanitarian Charter and Minimum Standards in Disaster Response”, which was devised in 2000 and has since had two revisions.²⁶

These codes are now practically “industry standards”. By no stretch of the imagination, however, can they be seen as an ethical framework for NGO policymaking and practice in the field of public health. They were not, of course, designed with that broad purpose in mind; their focus is much narrower – disaster relief or response. They were also crafted by

25 www.icrc.org/en/publications-and-reports/code-of-conduct/ (accessed 1 September 2011).

26 www.sphereproject.org (accessed 1 September 2011). A third example is the Humanitarian Accountability Partnership’s (HAP) “Standard in Humanitarian Accountability and Quality Management”, www.hapinternational.org (accessed 1 September 2011); see, in particular, HAP, *The Guide to the HAP Standard* (Oxford: Oxfam Publishing 2008). See more generally the International NGOs Accountability Charter, available at www.ingoaccountabilitycharter.org (accessed 1 September 2011), and the ongoing project of the International Council on Human Rights Policy, www.ichrp.org/invitation_to_dialogue_en.pdf (accessed 1 September 2011).

and for humanitarian organisations, not their human rights counterparts. Still, given that disasters have been a key site of NGO public health work, these codes merit scrutiny here. Indeed, if it can be established that these codes address the ethical considerations that confront human rights NGOs in disaster sites, then at least part of the project to build an account of NGOs and “public health: ethical issues” is already complete.

Let’s start with the Red Cross code; specifically, principle 2 which states that “[a]id is given regardless of race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.” My own reaction to this principle is akin to that of Jennifer Rubenstein, who asks: “What precisely is it prescribing?”²⁷ As Rubenstein points out, the sentences that make up principle 2 – the first foregrounding non-discrimination, the second calling for “need alone” to be determinative – are no self-evident partnership. In particular, there is nothing about non-discrimination that compels a needs-based approach; maximising harm reduction, for instance, might be just as compatible with the principle of non-discrimination. More generally, where need exceeds aid, focusing on “need alone” will not offer decisive guidance on either the sorting of needs or the day-to-day selection (and thus non-selection) of individuals.

Prioritising “most urgent need” might be an option here, but it too calls for further scrutiny. Sorting and selection – human rights triage²⁸ – are not going to be eliminated by the use of an urgency criterion; indeed, they may become more complex given that the criterion calls for a border between urgent and less urgent need that will have to be established and then policed. Moreover, the prior question, concerning why need (rather than, say, maximising harm reduction) has been chosen, still has to be answered too.²⁹ Finally, whether need or urgent need is the criterion, NGOs will still face follow-on questions about the impact of their interventions. For example, are their interventions meeting need partly by luring locals to “NGoland”,³⁰ draining the primary healthcare system of trained staff? And are they also wreaking havoc on the prospects of local (fee-based) services?

The Sphere code is not problem-free either. To illustrate this point, let’s take a brief look at its emphasis on minimum standards. There is, of course, clear affinity between that emphasis and a human rights-based approach; minimum standards provide a threshold below which protection should not fall, and the idea of “minimum core obligations” has been promoted by the Committee on Economic, Social and Cultural Rights (CESCR), the treaty body responsible for the International Covenant on Economic, Social and Cultural Rights (ICESCR).³¹ At the same time, however, and especially amidst an emergency, a

27 J C Rubenstein, “The distributive commitments of international NGOs” in M Barnett and T G Weiss (eds), *Humanitarianism in Question: Politics, power, ethics* (Ithaca: Cornell UP 2008), pp. 218–19.

28 Here I am drawing on the discussion of triage in P Redfield, “Sacrifice, triage, and global humanitarianism” in Barnett and Weiss, *Humanitarianism in Question*, n. 27 above, p. 196.

29 Of course, as noted by Rubenstein, “The distributive commitments”, n. 27 above, p. 222: “It is possible that, if NGOs intentionally tried to maximally reduce harm in every decision that they made, they would miscalculate, cut corners, find the process overly psychologically taxing, or spend too much time and money collecting information. Paradoxically, therefore, it might be that NGOs will do more to reduce harm if they comply with the principle of prioritizing the worst off than they would if they straightforwardly tried to act on the principle of maximally reducing harm.”

30 P Farmer, “Challenging orthodoxies: the road ahead for health and human rights” (2008) 10 *Health and Human Rights* 5, p. 10, available at www.hhrjournal.org/index.php/hhr/article/view/33/100 (accessed 1 September 2011). In elaborating on principle 2, the Red Cross code states that: “Wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of disaster victims and the local capacities already in place to meet those needs.” (emphasis added) See also principles 6, 7, 8 and 9 of the code.

31 An excellent account is provided by K G Young, “The minimum core of economic and social rights: a concept in search of content” (2008) 33 *Yale Journal of International Law* 113.

minimum can readily become the ceiling not the floor as NGOs adjust downwards in light of local factors. Moreover, claims that minimum standards have to be met may encourage “quality assurance”, whereby NGOs limit the range of their interventions so as to boost levels of care and protection amongst the more select group that is being assisted. The point I am making here is not that NGOs that confine or contextualise are indisputably “bad” NGOs, but rather that a minimum standards approach is not always-and-everywhere synonymous with a fully fledged rights-based one: minima draw us towards survival, a vital goal, but in so doing they can draw us away from human dignity – including the need for NGOs to follow a dignity-infused approach when defining and meeting the requirements for survival.³²

The Red Cross and Sphere codes present other difficulties too. Two, in particular, merit comment here: first, these codes were designed by and for humanitarian NGOs, not their human rights counterparts; and second, they target “disaster” rather than the full spectrum of public health. I think these, however, should be seen as *productive* difficulties; by this I mean they are difficulties that provoke helpful lines of enquiry. For example, they encourage us to enquire into the kind of NGO challenges that are produced when public health problems are framed as “disasters” or “emergencies”. NGOs themselves are no strangers to the logic of emergency; they have wielded it in response to both sudden crises and embedded or long-term ones, such as the HIV/AIDS epidemic and maternal mortality. The logic of emergency is also wielded by states and, increasingly, by the international community too. For the latter, emerging infectious diseases – from SARS and virulent new forms of influenza, to bioterrorism and both multi- and extensively drug-resistant forms of tuberculosis – have been a particular preoccupation. Indeed, over the last decade or so, these diseases have had a profound impact, immersing us in the need for “preparedness”, the pull of “action now” and the importance of governing the “exceptional”. In so doing they have shaped (and been shaped by) a new lexicon, one featuring not only variations on “preparedness” but also “risk”, “resilience” and various takes on “security”, including “biosecurity”, “human security” and what the World Health Organization (WHO) calls “global public health security”.³³

This makes for difficult terrain for human rights NGOs engaged in public health work. Looking first at the new lexicon, it is only human security that has overt human rights resonance;³⁴ by contrast, the other terms, and more generally the construction of particular public-health problems as emergencies, can make it difficult for human rights claims to get a fair hearing.³⁵ Second, attacking the logic of emergency is no plain and simple option for human rights NGOs. For all that it is misleading, this logic is not an out-and-out lie: the globalised world does have emerging epidemics and it does make sense for these to be of international concern. NGOs also have their own reasons for endorsing the logic of emergency. For example, they have been offered a “seat-at-the-table” by the revised

32 On dignity, survival and the minimum core, see generally M Salomon, “Why should it matter that others have more? Poverty, inequality and the potential of international human rights law”, available at www.lse.ac.uk/collections/law/wps/WPS2010-15-Salomon.pdf (accessed 1 September 2011).

33 WHO, *The World Health Report 2007: A safer future – global public health security in the 21st century* (Geneva: WHO 2007). For discussion of the lexicon’s terms, see T Murphy and N Whitty, “Is human rights prepared? Risk, rights and public health emergencies” (2009) 19 *Medical Law Review* 219, available at <http://medlaw.oxfordjournals.org/content/17/2/219.short> (accessed 1 September 2011).

34 See *Human Security Now* (New York: Commission on Human Security 2003).

35 See W Parmet, *Public Health and Social Control: Implications for human rights* (Geneva: International Council on Human Rights Policy 2009), available at www.ichrp.org/files/papers/173/public_health_and_social_control_wendy_parmet.pdf (accessed 1 September 2011).

International Health Regulations (IHR), which allow the WHO to use information about disease outbreaks provided by unofficial (that is, non-state) sources.³⁶

In practice, specialist public health surveillance networks and institutions (such as GOARN,³⁷ which was established by WHO itself) are far more likely than NGOs to be in a position to provide relevant information on outbreaks. Nonetheless the underlying shift away from states as the sole voice on public health matters does help to establish the legitimacy of non-state perspectives, including, of course, those of human rights NGOs. More generally, rising global interest in public health emergencies, of which the revised IHR are one sign, offers NGOs a means by which they may be able to lift particular public health problems from a state of neglect to the resource-rich international stage; a means perhaps to emulate the widely envied success of the HIV/AIDS campaign for universal access to treatment.

The problem, of course, is that the logic of public health emergency is also misleading. For starters, its focus on emerging epidemics – on the future – may be exacerbating neglect of people who are dying today of public health problems, such as maternal mortality, that are entirely solvable. Second, the logic of emergency pitches public health together with security, protection with policing, disaster with crime – a matrix that is likely to favour criminal law-focused approaches and solutions to public health problems. And, thirdly, in the logic of public health emergency, drugs are dominant. Today's public health emergencies are “drug emergencies”; the underlying determinants of the public's health – including sanitation, water and the quality of the primary health infrastructure – lag a long way behind. Immediate access to drugs can, of course, be life-saving: a sudden outbreak of cholera clearly is a public health emergency that is a drug emergency. Nevertheless, as I explain below, the equation “public health = drugs” – what others have called “the pharmaceuticalisation of public health”³⁸ – has its downsides too.

HUMAN RIGHTS, HUMANITARIANISM AND “HUMAN RIGHTS-LITE”

At this juncture, let's go back to the other difficulty arising from the Sphere and Red Cross codes: namely, that these codes were developed by and for humanitarian NGOs, rather than their human rights counterparts. The reason I see this difficulty as productive, or helpful, is that it directs attention towards the relationship between humanitarianism and human rights. In so doing it encourages us to ask: in what ways, and with what effects, are humanitarianism and human rights connecting and disconnecting in the field of public health, in particular amidst rising interest in ESC rights on the part of human rights NGOs?³⁹

The NGO world is clearly one of the places we can look to answer that question. And if, within that world, we look at the Sphere code, a code produced by and for *humanitarian* NGOs, we find quite considerable use of the language of human rights. More tellingly, the Nobel Prize-winning and avowedly humanitarian NGO Médecins Sans Frontières (MSF) has become involved in both the provision of HIV/AIDS treatment and a campaign on

36 World Health Assembly, International Health Regulations, WHO Doc. WHA58/2005/REC/1 (23 May 2005), www.who.int/csr/ihr/IHRWHA58_3-en.pdf (accessed 1 September 2011), Articles 9, 10 and 11. “When justified by the magnitude of the public health risk”, WHO is empowered to share information with other states when the affected state is not cooperating with its verification and control efforts.

37 GOARN stands for Global Outbreak Alert and Response Network, www.who.int/csr/outbreaknetwork/en/ (accessed 1 September 2011).

38 See A Petryna and A Kleinman, “The pharmaceutical nexus” in A Petryna, A Lakoff and A Kleinman (eds), *Global Pharmaceuticals: Ethics, markets, practices* (Durham NC: Duke UP 2006).

39 The question of connections and disconnections between international human rights law and international humanitarian law in the context of *armed conflict*, in particular the “convergence” thesis, may well be pertinent here too: see N K Modirzadeh, “The dark sides of convergence” (2010) 86 *US Naval War College International Law Studies (Blue Book) Series* 349.

access to essential medicines, which includes the funding and management of R&D on new drugs. In so doing, MSF does not appear to have made any public shift towards human rights; in fact, as Peter Redfield points out, at MSF there seems to be “continued avoidance of human rights rhetoric”.⁴⁰ Yet, as Redfield goes on to explain, it is hard to see how either the provision of HIV/AIDS treatment or advocacy and research on essential medicines can claim to be conventionally humanitarian; they are, frankly, far more akin to a *rights*-based approach.⁴¹ More than this, given that HIV/AIDS treatment – to be successful – requires more than access to medicines, these initiatives may draw MSF deep into human rights terrain, taking it well beyond the claim of universal access to treatment. The reason for this is simple: treatment may save lives, it may even be “one of the most potent prevention tools we have”,⁴² but people do not live on treatment alone. Moreover, if there is a shortage of transport to and from the health centre, or a lack of clean water, even the offer of free treatment will be compromised.

MSF’s drug initiatives could pan out differently, however. In particular, they could pull the organisation towards what we may call “human rights lite”.⁴³ The initiatives could, for example, tighten the grip of pharmaceuticalisation, entrenching the drug emergency as the core way in which state and non-state actors alike think about public health. More to the point, MSF is by no means the only actor on this particular frontier. Today, looking at the HIV/AIDS epidemic – widely regarded as an NGO success story and, more broadly, a human rights one – it is clear that the centrality of treatment and testing can encourage a shrunk sense of what it is to take a rights-based approach. Universal access to treatment is, to be sure, a vitally important goal. But as emphasised earlier, programmes of treatment and voluntary testing cannot be the sum of a rights-based approach. If people are to avail themselves of services, and if they are to be able to use them on a long-term basis, programmes that attack stigma, discrimination, violence and all of the other barriers that prevent people from coming forward, or from continuing with treatment, need to be committed to as well. To put that more succinctly, rights-based approaches to public health “comprise more than packages of goods and services”.⁴⁴

Treatment and testing are crucial, but standing alone they are human rights-lite.⁴⁵ In addition, although mobilisation around universal access to HIV/AIDS treatment is one of the forces that helped to forge interest in global health policy, it has also intensified the grip of *disease-specific* programming. The problem with this, as Meier and Fox have pointed out, is that when priority is given to vertical interventions directed at particular diseases,

40 P Redfield, “Doctors without borders and the moral economy of pharmaceuticals” in A Bullard (ed.), *Human Rights in Crisis* (Aldershot: Ashgate 2008), pp. 139–40.

41 MSF’s human rights-inflected humanitarianism is not the only new configuration in the human rights/humanitarian relationship in the field of public health; there is also what might be described as humanitarian-inflected human rights. On the latter, see e.g. M Ticktin, “Medical humanitarianism in and beyond France: breaking down or patrolling borders” in A Bashford (ed.), *Medicine at the Border: Disease, globalization and security, 1850 to the present* (Basingstoke: Palgrave Macmillan 2006), p. 116.

42 Sidibé, *Delivering Results*, n. 24 above, p. 2.

43 See relatedly A M Klasing, P S Moses and M Satterthwaite, “Measuring the way forward in Haiti: grounding disaster relief in the legal framework of human rights” (2011) 13 *Health and Human Rights* 1, available at www.journal.org/index.php/hhr/article/view/408/610 (accessed 1 September 2011).

44 A E Yamin, “Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care” (2008) 10 *Health and Human Rights* 45, p. 48, available at www.hhrjournal.org/index.php/hhr/article/view/27/89 (accessed 1 September 2011).

45 See, relatedly, the idea of “biological citizenship” as developed by e.g. J Biehl, *Will to Live: AIDS therapies and the politics of survival* (Princeton: Princeton UP 2007); A Petryna, *Life Exposed: Biological citizens after Chernobyl* (Princeton: Princeton UP 2002).

primary health-care systems focused on the underlying determinants of public health tend to be neglected.⁴⁶

Moreover, NGOs play a very real part in this form of prioritisation, both because they champion particular diseases and because donors, looking for the best way to spend their money, may prefer to fund NGO provision rather than pursue the riskier strategy of giving to individual states in support of a considerably looser goal such as sector-wide health investment.⁴⁷

THE LIMITS OF HUMAN RIGHTS NGOS

MSF, as noted earlier, is a past winner of the Nobel Peace Prize. It is not, however, the only Peace Prize recipient amongst NGOs: in 1997 the prize went to Jody Williams and the cluster of NGOs that had come together to form the International Campaign to Ban Landmines.⁴⁸ One of those sharing that prize was Human Rights Watch (HRW), widely seen as the archetypal global human rights NGO. In recent years, both HRW and, its fellow global giant, Amnesty International have broadened out from their classic focus on civil and political rights, extending their remit so that they now include ESC rights. Amnesty explains the change of focus in the following way:

Amnesty International has broadened its mission in recognition that there are many more prisoners of poverty than prisoners of conscience, and that millions endure the torture of hunger and slow death from preventable disease.⁴⁹

And for HRW, according to the history pages on its website, it was the HIV/AIDS epidemic that led the organisation to develop a programme devoted to human rights and health.⁵⁰

Yet there have been demands for these NGOs to do still more; most notably from Paul Hunt, the first UN special rapporteur on the right to health, who argued that “civil society within the health and human rights movement could and should be doing much more”, and that established NGOs should be working on health and human rights issues “just as vigorously as they already campaign on disappearances, torture and prisoners of conscience”.⁵¹ Kenneth Roth of HRW sees things differently, however.⁵² Roth has argued that:

46 B Mason Meier and A M Fox, “International obligations through collective rights: moving from foreign health assistance to global health governance” (2010) 12 *Health and Human Rights* 61, available at www.hhrjournal.org/index.php/hhr/article/view/203/298 (accessed 1 September 2011).

47 Ibid. p. 62.

48 www.icbl.org (accessed 1 September 2011). Their work helped forge the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction (Mine Ban Treaty), entered into force 1 March 1999, 36 ILM (1997) 1507. For a critical account, see K Anderson, “The Ottawa Convention banning landmines: The role of international non-governmental organizations and the idea of international civil society” (2000) 11 *European Journal of International Law* 91.

49 Amnesty International, *Human Rights for Human Dignity: A primer on economic, social and cultural rights* (London: Amnesty International 2005), p.4.

50 See “Our history”, available at www.hrw.org (accessed 1 September 2011).

51 “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt”, UN Doc. A/HRC/4/28 (17 January 2007), para. 37.

52 K Roth, “Defending economic, social, and cultural rights: practical issues faced by an international human rights organization” in D A Bell and J-M Coicaud (eds), *Ethics in Action: The ethical challenges of international human rights nongovernmental organizations* (New York: CUP 2007), p. 169. See relatedly S Hopgood, “Dignity and ennui” (2010) 2 *Journal of Human Rights Practice* 151.

when outsiders ask international human rights organizations such as Human Rights Watch to expand our work on ESC rights, we should insist on a more sophisticated, and realistic, conversation than has been typical so far.⁵³

He says that, in his experience, advice to international human rights NGOs to “do more” to protect ESC rights has tended to be “little more than sloganeering”.⁵⁴ In particular, he says, “it . . . ignores the question of which issues can and cannot effectively be taken up by international human rights organizations that rely on shaming to generate public pressure”.⁵⁵

HRW, Roth’s own organisation, is well known for its use of a shaming methodology. Roth’s core claim is that, if this methodology is to be effective, there has to be clarity on three fundamentals: the violation, the violator and the remedy. He maintains that “[i]f any of these three elements is missing, the capacity to shame is greatly diminished”.⁵⁶ The difficulty with ESC rights, of course, is that this clarity can be hard to achieve: responsibility tends to be multiple not singular, and the question of what would be an appropriate remedy is often disputed. The upshot, according to Roth, is that HRW’s shaming methodology simply does not work for violations of ESC rights bar in that subset of cases where it is possible to pinpoint arbitrary or discriminatory conduct that is causing, or substantially contributing to, the violation:

[I]f all an international human rights organization can do is argue that more money be spent to uphold an ESC right – that a fixed economic pie be divided differently – our voice is relatively weak . . . On the other hand, if we can show that the government (or other relevant actor) is contributing to an ESC shortfall through arbitrary or discriminatory conduct, we are in a relatively powerful position to shame: we can show a violation (the rights shortfall), the violator (the government or other actor, through its arbitrary or discriminatory conduct), and the remedy (reversing that conduct).⁵⁷

There is more detail in Roth’s account but let’s see how these basics might measure up in an ethics test. We should begin by acknowledging that there is more than one way of doing good in the world, and indeed that this is a good thing; “cookie-cutter” NGOs would not be attractive or useful. It is also important to acknowledge that we are not dealing with a “blank slate”:⁵⁸ HRW has a history, which means that members and contributors alike have particular expectations and this in turn means that veering too far from those expectations might be akin to hitting a self-destruct button. Because of its history, HRW also has a specific expertise; expertise that might not be so useful in the field of public health or health rights more generally.

On the other hand, though, HRW is no ordinary NGO. It is, indisputably, a gatekeeper NGO – issues that are taken up by it are a great deal more likely to gain a global audience, and that in turn brings funding and other forms of momentum too. Moreover, for all that there is no blank slate, the priority that HRW gives to shaming is surprising at a time when human rights method is a growth area, as evidenced, for example, by expanding interest in

53 Roth, “Defending economic, social, and cultural rights”, n. 52 above, p. 180.

54 Ibid. p. 170.

55 Ibid.

56 Ibid. p. 173.

57 Ibid. p. 174.

58 J H Carens, “The problem of doing good in a world that isn’t: reflections on the ethical challenges facing INGOs” in Bell and Coicaud, *Ethics in Action*, n. 52 above, p. 260.

impact assessment, indicators and human rights budgeting,⁵⁹ and by the use of quantitative methods as a prosecution tool at the International Criminal Tribunal for the former Yugoslavia.⁶⁰

To be clear: I am not suggesting that HRW should abandon its shaming methodologies, that newer human rights methods are better or, indeed, that Roth is wrong when he says that responsibility for violation of ESC rights is often multiple. The claim instead is that gatekeeper NGOs, precisely because they are gatekeepers, should be seen as having particular responsibilities. Where a gatekeeper NGO frames shortcomings in ESC rights as, by and large, outside its remit – where it frames such shortcomings as mostly “matters of pure distributive justice”⁶¹ – it sends a message about what is, and what is not, a human rights matter. In so doing, it may cause harm to the standing of ESC rights both as a prompt for claims-making and as a component part of the law.⁶² And that in turn increases the risk that these rights will be thrown back onto a frame dominated by the language of needs, and of the deserving and undeserving. It also threatens the progress that has been made towards treating ESC rights as rights “proper” rather than, say, directive principles, and it offers less than fulsome support to the position of the CESC which sees “all members of society” as possessing certain “responsibilities regarding the realization of the right to health”.⁶³ Other harms could follow too, not least more limited openings for solidarity between gatekeeper NGOs and their local and national counterparts and also, crucially, less room for manoeuvre for the latter.⁶⁴

It seems to me that mindset, not methodology, may be the main obstacle. HRW has in fact been able to engage with a range of public health problems in recent years, from disasters and displaced populations to sexual and reproductive health.⁶⁵ There are also several new openings for the organisation’s preferred shaming methodology, both in the field of ESC rights in general and in public health in particular. To start with, ESC rights are now guaranteed in a significant number of constitutions and, as we saw earlier, at least one NGO, South Africa’s TAC, has used a constitutional guarantee of the right to have access to health-care services⁶⁶ as part of its successful campaigning on public health matters. Another opening is provided by the new optional protocol to the ICESCR⁶⁷ which, when it enters into force, will allow CESC to receive and consider individual complaints

59 See generally T Murphy, *Health and Human Rights* (Oxford: Hart forthcoming).

60 P Ball, W Betts, F Scheuren, J Dudukovich and J Asher, *Killings and Refugee Flow in Kosovo March–June 1999: A report to the International Criminal Tribunal for the former Yugoslavia* (Washington: American Association for the Advancement of Science 2002). See, relatedly, J Hagan, H Schoenfeld and A Palloni, “The science of human rights, war crimes, and humanitarian emergencies” (2006) 32 *Annual Review of Sociology* 329, p. 329, calling for the development of a “critically informed sociological synthesis that joins our understanding of the . . . health and violence dimensions of . . . ‘complex’ humanitarian emergencies”.

61 Roth, “Defending economic, social, and cultural rights”, n. 52 above, p. 179.

62 See, relatedly, K G Young, “Freedom, want, and economic and social rights” (2009) 24 *Maryland Journal of International Law* 191.

63 CESC, “General Comment No. 14: The right to the highest attainable standard of health (art. 12)”, UN Doc. E/C.12/2000/4 (11 August 2000), para. 42. See also the Universal Declaration of Human Rights, UN Doc. A/810 (10 December 1948), preamble and Article 28.

64 See L S Rubenstein, “How international human rights organizations can advance economic, social and cultural rights: a response to Kenneth Roth” (2004) 26 *Human Rights Quarterly* 845; Yamin, “Will we take suffering seriously?”, n. 44 above.

65 See e.g. HRW, “‘Nobody remembers us’: failure to protect women’s and girls’ right to health and security in post-earthquake Haiti” (2011), available at www.hrw.org/sites/default/files/reports/haiti0811.webwcover.pdf (accessed 1 September 2011).

66 South African Constitution 1996, s.27.

67 Optional Protocol to the ICESCR, UN Doc. A/RES/63/11 (adopted 10 December 2008; not yet in force).

concerning alleged violations of Covenant rights. And, as Roth himself seems to recognise,⁶⁸ the human rights responsibility of international co-operation and assistance could be used to produce a third opening.⁶⁹ As pointed out by the first UN special rapporteur on the right to health, the “contours, content and legal nature”⁷⁰ of this responsibility need to be spelled out more clearly. The special rapporteur’s own report on the matter uses Sweden as a case study, praising the country as a model high-income state – “[f]rom a right-to-health perspective . . . its international policies on development, health and human rights are among the best in the world”⁷¹ – but noting that even this “model” state does not accept that it has a *legal* obligation of international assistance and co-operation. Furthermore, even though both the special rapporteur and CESCR⁷² have emphasised that there is such an obligation, the stance taken by Sweden is by no means unique – rather, it is widespread amongst high-income states, which surely points to the importance of further human rights NGO advocacy on this issue.

The timing might be right too, in that rising interest in emerging infectious diseases – what WHO calls “global public health security” – may provide an opportunity to press claims for international assistance and co-operation. The revised IHR, for example, are premised on global interconnectedness. And the Nuffield report seems to draw on the same theme when it recommends applications of its preferred stewardship model “at the global level” or “on a global scale”.⁷³ Thus the report calls for compliance with the disease-notification requirements in the revised IHR, emphasising that “countries have an ethical obligation to reduce the risk of ill health that people might impose on each other across borders”.⁷⁴ It also calls on wealthy states to help improve “the capacities of developing countries to conduct effective surveillance of infectious diseases”; and it encourages “WHO, the international community and pharmaceutical companies” to build on existing pledges to improve manufacturing capacity for flu vaccines in developing countries.⁷⁵

Of course, all of these recommendations for global-level stewardship fit with what I described earlier as the logic of public health emergency; thus, they focus on emerging infectious diseases (as opposed to present-day killers or basic survival needs) and they give centre-stage to surveillance and drugs. Still, given that the emphasis on “security” helped to forge the human-rights-friendly concept of “human security”, it is surely possible that the idea of “stewardship ‘on a global scale’”, or indeed “global public health security”, given

68 Roth, “Defending economic, social, and cultural rights”, n. 52 above, 177: “If the issue is not how a foreign government divides a limited economic pie but how much money a Northern government or an international financial institution spends on international assistance for the realization of ESC rights, Northern-based international human rights organizations speak less as an outside voice and more as a domestic constituency.”

69 The obligation draws in particular on the UN Charter, Articles 1(3), 55 and 56; the Universal Declaration of Human Rights, Articles 22 and 28; and the ICESCR Articles 2(1), 11(1), 11(2), 15(4), 22 and 23. As regards health, the obligation is explained in CESCR, “General Comment 14”, n. 63 above.

70 “Report of the special rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt”, UN Doc. A/HRC/7/11/Add.2 (5 March 2008), para. 135.

71 Ibid. para. 134.

72 CESCR, “General Comment 14”, n. 63 above, para. 45: “For the avoidance of any doubt the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide ‘international assistance and cooperation, especially economic and technical’ which enable developing countries to fulfil their core and other obligations.”

73 Nuffield report, n. 1 above, paras 4.50 and 4.68 respectively. See also the Maastricht Principles on extraterritorial obligations of states in the area of economic, social and cultural rights (28 September 2011) available at www.icj.org (accessed 1 December 2011). At para. 4.49, the Nuffield report notes that “the stewardship model . . . is usually applied at the national level in relation to obligations that states have towards those affected by their laws and policies. However, it is also reasonable to apply it at a much higher level”.

74 Ibid. para. 4.50.

75 Nuffield report, n. 1 above, paras 4.50, 4.68.

their preoccupation with global interconnectedness, could in turn provide a way in for advocacy on the human rights responsibility of international assistance and co-operation.

SAVE THE WORLD?

Others may take a harder line on HRW-type arguments about what is, and is not, an appropriate project for global human rights NGOs. For example, the philosopher Thomas Pogge has made the exceptionally strong claim that “even a project that does more good than harm should be abandoned when a lot more net good can be achieved with the same resources elsewhere”.⁷⁶ The first point to make about this claim is that engaging with it is not easy. As I said earlier, human rights NGOs are widely seen as making an effort to do good in the world and that fact alone makes Pogge’s critique difficult, even indecent. Pogge himself says that the standard he sets is sure to prove “inadequate in various ways”.⁷⁷ But the problem seems to run far deeper: how precisely does one critique “good practice”, and is it wrong even to try?

Perhaps it is for one or both of these reasons that NGOs, by and large, refrain from criticising one another. Moreover, calling for auto-critique – for NGOs to engage in self-scrutiny – is not problem-free either. Self-scrutiny may now be standard practice for NGOs – demanded by donors, expected by supporters and embraced by NGOs themselves as a way to assess whether and how desired outcomes are being achieved⁷⁸ – but scrutiny on *ethics* seems to be of a different order. There are at least four reasons for this. First, inside individual NGOs the view from the field tends to differ from that in head office, especially on the question of human rights triage. Logical or principled choices about selection and non-selection generally feel less logical and less principled when one is face-to-face with the people who are going to be affected in profound ways by these choices. As Redfield has pointed out, from a local perspective, “the end of engagement is less clearly justifiable, and appears akin to abandonment or sacrifice of that population”.⁷⁹ What I take from this is that, if not handled with extreme care, auto-critique on the ethics of human rights triage could rupture the organisational culture of individual NGOs.

Second, not all publicity is good publicity and encouraging human rights NGOs to go public on how they handle difficult ethical issues could have damaging repercussions.⁸⁰ We tend to think of human rights NGOs as actors who target others; in so doing we sometimes forget that NGOs can be targets too. We forget that they have no immunity against manipulation or, indeed, direct attacks on their personnel or the goods they provide. NGOs also face both hostility and scepticism; indeed, as the profile of human rights NGOs has risen in recent years, so too has the criticism they face. In some ways this is fair enough: NGO transparency and accountability are important matters.⁸¹ There are critics who seek far more than this, however; critics who do not want human rights NGOs to survive

76 T Pogge, “Respect and disagreement: a response to Joseph Caren” in Bell and Coicaud, *Ethics in Action*, n. 52 above, p. 273.

77 Ibid. p. 278.

78 See e.g. I Gorvin, “Producing the evidence that human rights advocacy works: first steps towards systematized evaluation at Human Rights Watch” (2009) 1 *Journal of Human Rights Practice* 477.

79 Redfield, “Sacrifice, triage, and global humanitarianism”, n. 28 above, p. 198. See also R C Fox and E Goemaere, “They call it ‘patient selection’ in Khayelitsha: the experience of Médecins sans Frontières-South Africa in enrolling patients to receive antiretroviral treatment for HIV/AIDS” (2006) 15 *Cambridge Quarterly Healthcare Ethics* 302; C Sinding and L Schwartz, “‘Playing God because you have to’: health professionals’ narratives of rationing care in humanitarian and development work” (2010) 3 *Public Health Ethics* 147.

80 Rubenstein, “The distributive commitments”, n. 27 above, p. 215.

81 See e.g. S Charnovitz, “Accountability of non-governmental organizations in global governance” in L Jordan and P Van Tuijl (eds), *NGO Accountability: Politics, principles and innovations* (London: Earthscan 2006), p. 21.

scrutiny. Being transparent about human rights triage is not, then, straightforward – there are high stakes for NGOs, for their staff members who stay behind when other internationals have moved on, for locals who have worked with the NGO, and of course for others too who are left behind.⁸²

Third, NGOs are not, or not only, lone operators. Choosing a particular course of action, continuing with it and pulling out are actions where NGOs are influenced in part by donor sentiments. Moreover, NGOs today tend to seek out connections with one another; they may also be connected to international organisations, states and fellow non-state actors. TAC, for example, has worked with ACT-UP and COSATU (a South African trade union) amongst others. Similarly, MSF, an NGO that has been tenacious in protecting its own autonomy (including its right to bear witness to human rights violations, and to pull out of projects), opted to work with TAC and a range of other organisations as part of an access to medicines campaign. The point here is not that being in a network, or being in partnership, dissolves the need to consider ethics; simply, that it is likely to make their consideration and pursuit a good deal more difficult.

Fourth and finally, ethical considerations are not resource-neutral: resources spent on ethics are resources that are not being spent elsewhere – NGOs are not resource-rich enough for it to be any other way. Take, for example, participation: amongst human rights NGOs, participation by beneficiaries is widely seen as both an ethical imperative and a means of improving the likely effectiveness of a project. Yet resources spent on training NGO staff in modes of participation are resources that could have been spent in other ways.⁸³ And, although at first glance this may seem a foolish example (after all, why be against participation?), the rise of a new accountability culture amongst NGOs could produce an excess of posts in this arena (as well as “the ‘bureaucratic personalities’” that these positions sometimes encourage).⁸⁴

Still, even with these problems Pogge’s argument should not be dismissed out of hand. For starters, although we may want to insist that there is more than one way of doing good, there still has to be a way to identify NGOs that do harm. Put differently, even if agreement on what is good is unlikely, we can – and must – look for agreement on what is unarguably wrong. The phenomenon of “servile NGOs”⁸⁵ (that is, organisations that are government-sponsored and focused on serving a state interest, not a public one) makes this an important task. Interestingly, even the limited consideration of NGOs in the Nuffield report picks up on this point, noting that:

[a]lthough NGOs are often perceived as acting “for the good of the public” and therefore as more trustworthy than officialdom, it should be borne in mind that NGOs may have a vested interest, a commercial imperative and a “product” in a way that it not dissimilar to a business. Some may be sponsored by a commercial company with an interest or agenda in this area. An organisation that campaigns on behalf of a sector of the public with a particular kind of worry may even rely for its support on that worry being amplified and even distorted.⁸⁶

82 See relatedly P Alston, “The challenges of responding to extra-judicial executions: interview with Philip Alston” (2010) 2 *Journal of Human Rights Practice* 355, discussing the responsibilities of UN special procedures mandate-holders and of the UN Human Rights Council to those who assist their work on the ground.

83 Rubenstein, “The distributive commitments”, n. 27 above, p. 225.

84 C Heimer, “Side effects: accountability in international HIV/AIDS programs”, abstract available at www.princeton.edu/CCSO/seminars/carol-heimer/ (accessed 1 September 2011).

85 O de Frouville, “Domesticating civil society at the United Nations” in P-M Dupuy and L Vierucci (eds), *NGOs in International Law: Efficiency in flexibility* (Cheltenham: Edward Elgar 2008), p. 73.

86 Nuffield report, n. 1 above, para. 3.43.

Money, of course, is one area where NGOs have been willing to be critical of one another. Fundraising practices have been their principal target,⁸⁷ but what if we were to stretch the trend so as to look at other NGO practices concerning money? One question that comes immediately to mind is: given that human rights activism is often seen as a vocation, that volunteerism is prized, who should be paid for their work? For instance, is paying community health workers for the work they do on behalf of their neighbours, a vital element in the achievement of health and human rights goals or is it, as some would argue, an unsustainable practice?⁸⁸ And, as mentioned earlier, what are the ethical responsibilities of NGOs when their work creates “a local brain drain by luring nurses, doctors, and other professionals from the public hospitals . . . to ‘NGoland,’ where salaries are better and the tools of [the] trade more plentiful”?⁸⁹ Also, shifting ground a little, what about NGO interns – the recent graduates who have been declared winners in the fierce competition for short-term, unpaid appointments? I know from the classes I teach that, for human rights students, few jobs have more appeal, but what exactly are the ethical responsibilities of NGOs towards this unpaid workforce?⁹⁰

Of course, what matters to Pogge is something different. His concern is project selection⁹¹ by international NGOs, and in particular what he sees as the imperative to do more good rather than less. Assuming an NGO accepts this imperative, following through is not always going to be practicable: in choosing between projects, an NGO has to take account of more than what will do most good – its mission, for example, is also relevant to the calculation. The NGO may also be faced with insufficient information to allow it to complete a proper ranking as between the different choices.

Still, even with these caveats, Pogge’s imperative presents global NGOs with at least one compelling challenge: namely, to explain why they choose to “save the world” when they might be more effective – when they might do more good – if they were to apply limits to the geographic scope of their work.⁹² HRW, for example, is engaged in research and advocacy in around 90 countries.⁹³ Would it object to a contraction of the geographic scope of its efforts? If so, on what basis? As Joseph Carens has noted, “[i]t would be instructive to learn whether [NGOs such as HRW] think there is a deep, principled reason for the choices they make or whether it is a response to fund-raising or other imperatives”.⁹⁴

4 Conclusion

I close with an anecdote drawn from teaching human rights courses over a good number of years. The students in my classes are almost always interested in the relationship between academia and activism; at the same time, however, because many of them imagine their human-rights future working “in the field” (or perhaps at a headquarters in New York,

87 The use of images of suffering as a fundraising tool has been a particular flashpoint. Principle 10 of the Red Cross code tackles the problem in the following way: “In our information, publicity and advertising activities, we shall recognize disaster victims as dignified humans, not hopeless objects.”

88 Farmer, “Challenging orthodoxies”, n. 30 above, p. 8.

89 Ibid. p.10.

90 As regards Amnesty, see S Hopgood, *Keepers of the Flame: Understanding Amnesty International* (Ithaca: Cornell UP 2006), p. 19: “its inner working culture has often been unsympathetic and unforgiving, sacrificial even”.

91 Carens, “The problem of doing good”, n. 58 above, p. 270 makes this point, noting that choices about mission or basic strategy are, by contrast, “characterized by a much higher degree of uncertainty than Pogge allows for . . . although no one can doubt the wisdom of a general prescription that says do more good rather than less, other things being equal, it is often impossible to tell what will do more good” (p. 267).

92 Ibid. pp. 270–1.

93 Gorvin, “Producing the evidence”, n. 78 above, p. 479.

94 Carens, “The problem of doing good”, n. 58 above, p. 271.

London, Geneva or elsewhere), they will often ask why anyone wanting to do human rights would choose to be an academic not an activist. Viewed from a teaching perspective it is an excellent question. But, if I am honest, it is vexing too: it seems to suggest that this choice – the choice of what to be in human rights – is the crucial one. It is, of course, an important choice, one that will have consequences both for the individual making it and for the future of human rights. Yet choice does not end at this point: life as an academic involves choice, and choice is also part and parcel of human rights activism. Indeed, in the activists’ world, choice can be both relentless and oppressive; it can also be a matter of life and death – for activists themselves and for others too. Put simply, choice is abundant in the activists’ world.

That in a way is what motivated this article. True, the article itself engages with just one context – public health – wherein NGOs face choices: choices that are important for them, for other public health actors and, of course, for the rest of us too. The article proposes that wider recognition and debate concerning such choices would be a good thing – though it will be precarious too. More specifically, the article proposes a *revised* Nuffield report; a report that is more fully engaged with the phenomenon I have labelled “public health *sans frontières*”.

Were there to be such a report, I would like it to include the following. First, the relationship between human rights and humanitarianism in the public health arena, and perhaps more broadly too (say, in relation to the government of war and armed conflict). Second, the commitment of global human rights NGOs to public health issues, and the extent to which we ought to be concerned both about the scope of such commitments and about the form that they take. Third, the particular challenges of *human rights* triage: what are those challenges, and in what ways are they genuinely distinctive to human rights (because of its commitments, say, or perhaps because of its practices)? Does human rights need a set of ethics⁹⁵ to handle such challenges or just a more thorough and more open engagement both with extant principles, such as participation and non-discrimination, and with extant health and human rights practices, such as those of South Africa’s TAC? And, finally, I have also emphasised that global health security has to be part of the backdrop to any such discussion, not least because this new preoccupation is already producing both challenges and opportunities for human rights NGOs who work in the field of public health.

95 P Gready, “Introduction: responsibility to the story” (2010) 2 *Journal of Human Rights Practice* 177, p. 189, proposes an “enabling ethics” – albeit in a different, non-public health context.

